

DOCUMENTATION OF QUALIFIED MEDICATION AIDE PRACTICUM State Form 51650 (3-04) Indiana State Department of Health - Division of Long Term Care

This original form must accompany your application for testing

Student Name:	Name:			A CALLER TO THE TOTAL THE TOTAL TO THE TOTAL TOTAL TO THE	_ ISDH Approved QMA Training Program:	gram:	***************************************
Practicum Site:	ım Site:				TO	TOTAL PRACTICUM HOURS:	A ALL LAND TO THE
Read Di the ISDF	rections C	arefully: Lis	t complete t include tir	dates (including year) and complete t ne spent on other duties, breaks or	Read Directions Carefully: List complete dates (including year) and complete times (including am or pm). Document only time spent performing duties & tasks as mandated in the ISDH QMA program. Do Not include time spent on other duties, breaks or meals. Use multiple forms as necessary.	nly time spent performing duties & tar y.	ısks as mandated in
Date	Start	Ending Time	Total Time	Description of Tasks Completed	Practicum Supervisor (Printed Name)	Practicum Supervisor (Signature)	Student Initials
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Total P	Total Practicum Hours:	Hours:	5		import modication and treatment	odministration	
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RN QN	MA Progra	RN QMA Program Instructor	<u>Q</u>		Student Signature		Date